IN THE UNITED STATES COURT FOR THE DISTRICT OF UTAH

CENTRAL DIVISION

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DISTRICT OF UTAH

MICHAEL GEDDES and KARI GEDDES individual and as guardians of ANDREW GEDDES, a minor child, Plaintiffs, vs. UNITED STAFFING ALLIANCE EMPLOYEE MEDICAL PLAN; U.S.A. UNITED STAFFING ALLIANCE, L.L.C., a limited liability company and EVEREST ADMINISTRATORS, INC., a Utah corporation, Defendants.	MEMORANDUM OPINION GRANTING PARTIAL SUMMARY JUDGMENT TO PLAINTIFFS Case No. 2:03-CV-00440 PGC Judge Paul G. Cassell

Plaintiffs Michael, Kari, and Andrew Geddes, and defendants U.S.A. United Staffing Alliance, L.L.C., and Everest Administrators (collectively "United Staffing") have filed cross-motions for summary judgment on the Geddes's three pending Employment Retirement Income Security Act (ERISA) claims. The court has reviewed the pleadings and GRANTS the Geddes' motion for summary judgment on the first cause of action and GRANTS United Staffing's motion for summary judgment on the Geddes' second and third causes of action.

BACKGROUND

On June 27, 2002, Andrew Geddes dove in shallow water at Lake Powell and seriously injured his spinal cord. Andrew lost the ability to move his arms and legs, and his father quickly rescued him. Ultimately, Andrew was transported by air ambulance from Lake Powell to St. Mary's Hospital ("St. Mary's") in Grand Junction, Colorado. The physicians at St. Mary's determined that Andrew had severely injured his spinal cord and placed him in intensive care.

On July 1, 2002, Andrew underwent surgery to repair and align his spine. After surgery Andrew remained in the intensive care unit and a halo device was attached directly to Andrew's skull with pins. The halo device immobilized his spine. Andrew received intravenous hydration and nourishment while at St. Mary's until he left on July 15, 2002.

On July 15, 2002, Andrew was transferred via a five-hour ambulance ride to Primary Children's Hospital in Salt Lake City, Utah ("Primary Children's"). The physicians at St. Mary's requested Andrew be transported by air. United Staffing, however, denied coverage for this mode of transport.

When Andrew arrived at Primary Children's, he was placed in the neuroscience ward. Andrew was still in the halo and had splints on his arms and legs. Throughout his stay at Primary Children's, Andrew received care for complications due to his injuries. Because he was unable to eat or drink, he was intermittently fed and hydrated. His bladder and bowels were treated constantly. He was given enemas and catheters daily to prevent dysreflexia, a potentially deadly condition common in paralysis victims. He also received extensive rounds of medication for such things as pain control, bowels, bladder, infections, and spasticity. Throughout his stay, medical personnel also provided respiratory and radiological services. Primary Children's did not discharge Andrews from inpatient care until September 10, 2002.

Andrew's treating physician at Primary Children's – Dr. Terese Such-Neibar – stated that spinal cord injuries, such as Andrew's, typically require two months of in-patient care. She also concluded Andrew needed to remain at Primary Children's's until September 10, 2002, and could not have been released earlier.

The Plan

The Geddes were enrolled in the United Staffing Alliance Employee Medical Plan (the "Plan"). The Plan is an employee welfare benefit plan as defined under ERISA[1] and its terms are defined in the Summary Plan Description (also referred to as the "Plan"). The parties agree that Andrew was a covered dependent under the Plan at the time of the accident.

Defendant United Staffing is a fiduciary to the Plan[2] and provided copies of the Master Policy Description to the Geddes in 2002 and 2003. United Staffing contracted with a third party administrator, Everest Administrators, to perform the administrative functions of the Plan such as billing, payment, and customer service. Everest Administrators, referred some claims to Intracorp for review as well — Intracorp is another independent claim administrator delegated by United Staffing to review submitted claims. The Plan stated that *United Staffing* made all of the "final decisions about benefits paid from the Plan."[3]

The Plan states:

> The Plan will give the Participant *written* notice of any claim that is denied in whole or in part, listing the specific reasons for the denial. . . . If a Participant is not satisfied with the explanation of why payment was denied, the Participant can request that the claim be reviewed. . . . The Company will have the responsibility to make all final determinations regarding the claims for benefits under the Plan, and will have the right to interpret the terms and provisions of the Plan.[4]

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[1] 28 U.S.C. § 1000 *et seq.*

[2] 28 U.S.C. § 1104(a)(2000).

[3] Memorandum in support of Motion for Summary Judgment, Exhibit 3, p.1.

[4] *Id.*

While the Plan clearly states that "[t]he company will have the responsibility to make all final determinations regarding the claims for benefits under the Plan," Terry A. Ficklin, a partner owner of United Staffing, testified that United Staffing's role only was to meet annually with Everest to review exclusions and deductibles:

> Q: So if I understand what you are saying, [United Staffing] met with Everest and [United Staffing] determined the exclusions, correct?
>
> A: Correct, on an annual basis.
>
> Q: Right, and you determined things like deductibles? Is that correct?
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> A: Deductibles, yes.
>
> Q: On an annual basis?
>
> A: Prices.
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> . . .
>
> Q: . . . So when you say United Staffing makes all final decisions about benefits paid from the plan, that's what you are referring to is those annual determinations?
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> . . .
>
> A: Yes, that's my understanding of what that meant when they explained that part to me . . . .
>
> Q: Okay. So United Staffing never sits down and reviews a claim from a plan participant to determine whether the claim is going to be covered or not?
>
> A: We do not. Never have.
>
> Q: That's Everest's responsibility, correct?
>
> A: Yes.[5]

Through Everest, United Staffing contracted with care providers to provide services to plan participants at a discounted contract price ('Network Providers"). The Plan also provided coverage

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[5]Depo. of Terry A. Ficklin ("Ficklin Depo."), p. 31-32.

for care given by out of network providers. Specifically, "[f]or services provided by a non-participating provider," the Plan paid "the usual and customary amount as determined by the Plan."[6]

The Plan also defined several relevant terms:

> **In-patient treatment** - receiving care in a hospital or other facility provider as a registered patient and incurring a room and board charge.[7]
>
> **Hospital** - An institution which is engaged primarily in providing medical care to sick and injured persons on an in-patient basis, is appropriately licensed by the regulatory authority having jurisdiction, and is accredited by Joint Commission on Accreditation of Hospitals (JCAH).
>
> **Hospital Care.** Expenses for in-patient and outpatient services and supplies in a hospital. In-patient room and board charges are limited to the semi-private room rate. Hospital confinement primarily for physiotherapy, hydrotherapy, intravenous drug administration, convalescent care, or rest care are not covered.

Payment of Claims

St. Mary's billed the Geddes $86,460.70 for Andrew's care. United Staffing only paid $37,363.66 of these charges. Primary Children's billed the Geddes $99,431.98 for Andrew's care. United Staffing only paid $3,557.66 of these charges for lab work, X-rays, and other items during Andrew's stay. As an explanation, Everest sent standard claim form denials to the Geddes. One notice of denial of benefits stated that the claim was denied because the Geddes' annual limit of a certain category of service (rehabilitation) had been met. A second explanation of benefits stated that the claims were denied because they involved "In-patient Rehab or SNF (facility)."

On August 5, 2002, a letter from Everest stated that Intracorp had reviewed the claims. The letter explained the reason for continued denial somewhat cryptically as:

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[6] *Id.* at 28.

[7] *Id.* at 31.

> Noncertify continued stay 7/11 through discharge. Rationale: Information provided does not establish medical necessity for acute in-patient hospital care on above dates of service.

This letter invited the Geddes to appeal the decision. The letter specifically stated:

> In order for Intracorp to process an appeal, the following information must be provided to Intracorp by the treating physician:
>
> – Clinical reason for the requested service; and
> – Any other information that supports the request.
>
> The attending physician or requesting provider can provide this information telephonically if admissions/services are ongoing, or in writing if admissions/services have been discontinued. Please submit the appeal request, any additional clinical information, or questions related to this process to Intracorps's Appeal Coordinator at the above address and telephone number.[8]

The letter was signed by Dr. James Finke M.D., Physician Advisor, and did not list whether Dr. Finke worked for Intracorp or Everest. Confusingly, the letter listed the addresses of Everest Administrators and Intracorp at the top of the first page. On the top of the first page, Ms. Roberta Zumdahl was listed as the appeals coordinator at Intracorp.

On September 17, 2002, the Geddes sent a letter to Intracorp addressed to Ms. Roberta Zumdahl. The letter stated "I am officially appealing this decision. . ." and discussed the Geddes' contentions that the Plan did cover Andrew's care at Primary Children's because he needed "Acute In-Patient Hospital Care."[9] Neither Ronald Hulse (the president of Everest) nor Mr. Ficklin denied receiving this letter. Mr. Geddes indicates under oath he in fact sent this letter.[10]

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[8] Plaintiff's Memorandum in Support of Motion for Summary Judgment, Ficklin Deposition, Exhibit 7.

[9] *Id.*, Exhibit 9.

[10] *Id.,* Geddes Declaration,¶ 12.

Eventually on January 29, 2003, Mr. Hulse of *Everest* sent a response to the Geddes' attorney discussing the "request for reconsideration."[11] The letter stated, "We completely agree that the rehabilitation care was medically necessary."[12] Nonetheless, Everest denied the request for reconsideration based on the fact that, "Limits on long-term rehabilitation care are almost universal."[13] The Geddes then filed suit, asserting three claims: (1) violation of ERISA §§ 502(a)(1)(B) and 502(a)(3), (2) breach of fiduciary duty – a violation of ERISA §§ 404(a) and 502(a)(3), and (3) violation of ERISA § 502 (c)(1)(B). Soon thereafter, both parties filed cross motions for summary judgment.

SUMMARY JUDGMENT STANDARD OF REVIEW

Pursuant to Rule 56 of the Federal Rules of Civil Procedure, summary judgment "shall be rendered . . . if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits . . . show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law."[14] In applying this standard, the court must examine the evidence and reasonable inferences therefrom in the light most favorable to the non-moving party.[15]

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[11]Defendant's Memorandum in Support of Motion for Summary Judgment, Declaration of Lawrence Buhler, Exhibit L.

[12]*Id.*

[13]*Id.*

[14]Fed. R. Civ. P. 56(c).

[15]*See Gaylor v. Does*, 105 F.3d 572, 574 (10th Cir. 1997).

STANDARDS OF REVIEW FOR ERISA CLAIMS

Although ERISA, in 29 U.S.C. § 1132(a)(1)(B), allows plaintiffs "to recover benefits due under the [insurance] plan, to enforce rights under the terms of the plan, and to obtain a declaratory judgment of future entitlement to benefits under the provisions of the plan contract,"[16] nowhere do the ERISA statutes provide a judicial standard of review for such claims. The Supreme Court has filled this void by holding in *Firestone Tire and Rubber Co. v. Bruch* in 1989 that "a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard *unless* the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan."[17] When an insurer retains discretionary authority, the insurer's interpretation and decision must be upheld "unless it was arbitrary and capricious."[18]

Notwithstanding the standard set forth in *Firestone*, "[t]o be entitled to deferential review, not only must the administrator be given discretion by the plan, but the administrator's decision in a given case must be a valid exercise of that discretion."[19] In *Gilbertson v. Allied Signal, Inc.*, the Tenth Circuit found that the plan's administrator was not entitled to a deferential standard of review because the company "never got around to exercising its discretion or applying its administrative expertise to reach a final decision."[20] Therefore, "if 'a trustee fails to act or to exercise his or her discretion, *de novo* review is appropriate because the trustee has forfeited the privilege to apply his

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[16]*Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 108 (1989) (citing 29 U.S.C. § 1132(a)(1)(B)).

[17]*Id*. at 115 (emphasis added).

[18]*Chambers v. Family Health Plan Corp.*, 100 F.3d 818, 825 (10th Cir. 1996).

[19]*Gilbertson v. Allied Signal, Inc.*, 328 F.3d 625, 631 (10th Cir. 2003).

[20]*Id*. at 636.

or her discretion; it is the trustee's analysis, not his or her right to use discretion or a mere arbitrary denial, to which a court should defer.'"[21]

During the summary judgment hearing held before the court, all parties agreed that Everest — the company to which United Staffing delegated its authority to review and evaluate claims — was not a fiduciary and had no fiduciary duties to the Geddes. In fact, when counsel for United Staffing inferred that Everest owed fiduciary duties to the Geddes, counsel for Everest quickly corrected counsel by making clear that it is not a fiduciary to the Geddes. United Staffing's counsel agreed. This is also reflected in the contract between United Staffing and Everest. The service agreement specifically states that Everest is not to be a fiduciary and that it is not to be the party responsible for making final benefits determinations. Furthermore, there is no evidence that United Staffing ever reviewed any of Geddes's claims. Because Everest was the only party that reviewed Geddes's claims, and because it is undisputed that Everest is not a fiduciary to the Geddes, the court finds that at no point did a fiduciary for the Geddes ever evaluate their claims. Consequently, because the fiduciary in this case — United Staffing — opted not to exercise its self-delegated discretionary authority, it is presumed to have waived its right to deferential review as held by the Tenth Circuit in *Gilbertson*.[22] A brief explication of this conclusion may be appropriate.

Under ERISA, "[e]very employee benefit plan shall be established and maintained pursuant to a written instrument. Such instrument shall provide for one or more *named fiduciaries* who jointly or severally shall have authority to control and manage the operation and administration of

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[21] *Id*. at 633 (quoting *Gritzer v. CBS, Inc.*, 275 F.3d 291, 296 (3rd Cir. 2002)).

[22] *Gilbertson*, 328 F.3d at 633.

the plan."[23] ERISA further provides that a named fiduciary may delegate its fiduciary responsibilities: "The instrument under which a plan is maintained may expressly provide for procedures . . . (B) for *named fiduciaries to carry out fiduciary responsibilities* . . . under the plan."[24]

As defined by the Plan:

> [United Staffing] is the *named fiduciary* and is the plan administrator of the Plan. [United Staffing] will engage an *independent* claims administrator to administrate the Plan, however, [United Staffing] makes *all final decisions* about benefits paid from the Plan.[25]

Additionally, the appeals section of the Plan clearly states that United Staffing "will have the responsibility to make all final determinations regarding claims for benefits under the Plan, and will have the right to interpret the terms and provisions of the Plan."[26] And lastly, in that same section, United Staffing reiterates its role as fiduciary: "The people who operate this Plan are called 'fiduciaries' of the Plan, and they have a duty to operate the Plan prudently and in the interest of Plan Participants."[27]

For deferential review of a discretionary decision to apply, the party delegated the responsibilities to review claims should also be a named fiduciary. In the Ninth Circuit case of *Madden v. ITT Long Term Disability Plan for Salaried Employees*,[28] the insurance provider (ITT) delegated its fiduciary duties to Metropolitan Life Insurance Company. After Madden submitted a

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[23]ERISA, 29 U.S.C. § 1102(a)(1).

[24]ERISA, 29 U.S.C. § 1105(c)(1) (emphasis added).

[25]Plan, p. 1 (emphases added).

[26]Plan, p. 34.

[27]Plan, p. 35.

[28]914 F.2d 1279, 1281 (9th Cir. 1990), *cert. denied*, 498 U.S. 1087 (1991).

claim, Metropolitan reviewed Madden's file and responded by terminating Madden's benefits.[29] At Madden's request, Metropolitan reviewed its own decision and reaffirmed its decision to terminate benefits.[30] Later, again at the request of Madden, Metropolitan conducted another review, this time by requesting an independent outside agency to perform its own assessment — the decision was the same.[31] In holding that Metropolitan's decisions were subject to deferential review, the Ninth Circuit explained:

> In accordance with the logic and reasoning of *Firestone*, we hold that where (1) the ERISA plan expressly gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan and (2) pursuant to ERISA . . . a named fiduciary properly designates *another fiduciary*, delegating its discretionary authority, the 'arbitrary and capricious standard of review for ERISA claims brought under § 1132(a)(1)(B) applies to the designated ERISA-*fiduciary* as well as to the named fiduciary.[32]

While this holding is helpful to insurance providers who delegate some of their responsibilities, it does not apply here in light of the undisputed fact that Everest is not a fiduciary. In *Madden*, it was important that "the Plan named ITT as Plan administrator and fiduciary and expressly authorized ITT's Board of Directors to appoint a Long-Term Disability ("LTD") Administration Committee to have responsibility for carrying out all phases of the Administration of the Plan."[33] Furthermore, in that case "[t]he Plan, as permitted by § 1105(c)(1), also expressly

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[29] *Id*. at 1281-82.

[30] *Id*. at 1282.

[31] *Id*.

[32] *Id*. at 1283-84.

[33] *Id*. at 1284 (internal quotations omitted).

authorizes the LTD Administration Committee to designate another person *as fiduciary* for the administration of the Plan[.]"[34] Specifically, the key language of the Plan stated:

> The LTD Administration Committee may delegate its authority with respect to the denial, granting, and administration of claims to a claim administrator, which may be an insurance company or other appropriate *named fiduciary* and may enter into a Claims Administration Agreement with such claim administrator for the handling and determination of claims including, but not limited to, the granting or denial of claims and any appeals therefrom.[35]

In determining whether ITT appropriately delegated *fiduciary* responsibilities to Metropolitan, the court looked to the Claims Administrative Agreement entered into between ITT and Metropolitan:

> Upon receipt of a claim, Metropolitan shall review the claim including evaluation by Metropolitan's consultants when required, and determine whether it has been properly filed and the amount, if any, which is due and payable with respect thereto. In making benefits payments, Metropolitan will determine the validity of each claim presented and will, as necessary, make appropriate investigations within the time prescribed for processing of claims. . . .
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> . . . . .
>
> If benefits are to be wholly or partially denied, Metropolitan shall notify the claimant within a reasonable period of time. . . . *Metropolitan will have fiduciary responsibility for provision of full and fair review of claim denials*. . . . Final determination of payment or denial of appealed claims will be made following appropriate analysis and review.
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> . . . . .
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> [I]n the event ITT determines that Metropolitan has misinterpreted the Plan and so informs Metropolitan in writing of such appropriate interpretation, and such interpretation is deemed not unreasonable and not inconsistent with the terms of the Plan to Metropolitan, all claims processed after delivery of such writing to Metropolitan shall be administered in accordance with the interpretation of ITT.[36]

After examining ERISA, the Plan, and the Claims Administration Agreement, the Ninth Circuit held that "[b]ecause the Plan gives the LTD Administration Committee discretionary authority and the

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[34]914 F.2d at 1284. (emphasis added).

[35]*Id*. (emphasis in original omitted; emphasis added).

[36]*Id*. at 1284-85 (emphasis in original).

Committee has *properly designated Metropolitan as ERISA fiduciary*, we review Metropolitan's decision to terminate Madden's Plan benefits under the more deferential 'arbitrary and capricious' standard."[37]

This case is quite distinguishable because of the plain language of the Plan at issue here. The Claim Administration Agreement entered into by Everest and United Staffing lacks comparable language delegating fiduciary responsibilities to a third party. The contract clearly states that Everest is *not* a fiduciary, nor is it responsible for making final decisions.

The court has found one case in which a non-fiduciary's decision to deny benefits was reviewed under the "arbitrary and capricious" standard. That case, however, is wholly distinguishable from this one. In *Dinote v. United of Omaha Life Insurance Co.*, the U.S. District Court for the Eastern District of Pennsylvania held that *de novo* review did not apply because, despite the fact that a non-fiduciary physician reviewed the claim, the entire record indicated that the insurance company, "not the non-fiduciary physician, made the final determination to deny Plaintiff's application for . . . benefits."[38] More specifically, instead of denying plaintiff's appeal based solely on the non-fiduciary's report, the insurance company performed another claim review shortly after receiving the report; the insurance company also requested that plaintiff and her doctor submit additional medical information for further consideration of her claim.[39] Based on this evidence, the court held that "[b]ecause the fiduciary *actually made* the final determination . . . , the

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[37]*Id*. at 1285 (emphasis added).

[38]331 F. Supp.2d 341, 345 (E.D. Penn. 2004).

[39]*Id*.

de novo standard of review does not apply, and the arbitrary and capricious standard is used instead."[40]

Unlike the insurance company in *Dinote*, there is no evidence suggesting that the Plan Administrator here (United Staffing) "actually made" the decision to deny the Geddes' claim. United Staffing's partner owner, Mr. Ficklin, made this clear in his deposition testimony:

> Q: So United Staffing never sits down and reviews a claim from a plan participant to determine whether that claim is going to be covered or not?
>
> A: We do not. Never have.[41]

Speaking to the question of whether United Staffing was ever involved in an appeal process of any claim, Mr. Ficklin again said no. Regarding the specific care Geddes received:

> Q: Would it be fair to say that you don't know any of the specifics? And again, when I say you, I am talking about United Staffing know any of the specifics of the care that he received subsequent to his accident?
>
> A: Not the specifics, to my knowledge.[42]

And finally, regarding simple matters such as how out-of-network versus in-network providers would be treated, Mr. Ficklin, again speaking on behalf of United Staffing, indicated that he had "no idea" how a claim was handled differently depending on whether it was an outside of network provider who had rendered the services that are subject of the claim or whether it was an in-network provider.[43] It is also clear from Mr. Ficklin's deposition that United Staffing had no involvement in determining the "usual and customary" amount paid to out-of-network providers:

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[40] *Id*. at 345-46 (emphasis added).

[41] Ficklin Depo., p. 32, at 13-22.

[42] *Id*. at 55-56.

[43] *Id*. at 42, 16-24.

Q: . . . do you know how the plan determined the usual and customary amount that's referred to in that sentence . . .?

A: I do not.

Q: Again, United Staffing, do they have anything to do with . . . determining the usual and customary amount?

A: We do not.[44]

In sum, the evidence demonstrates without dispute that the final determinations regarding the Geddes' claims were never reviewed by a fiduciary. In light of this finding, the court holds that United Staffing waived its right to deferential review on any of the claims. Notwithstanding, United Staffing's retention of discretionary authority through language in the Plan, this case is covered by the Tenth Circuit's exception to the "arbitrary and capricious" standard of review: *de novo* review is appropriate if an administrator disregards claims and appeals procedures or opts not to exercise its discretion.[45] Based on this conclusion, the court need not determine whether *de novo* review is required because, as the Geddes argue, United Staffing failed to follow its claims and appeals procedures.

ANALYSIS

While the Geddes' complaint asserted three causes of action, the majority of the briefs and oral argument addressed primarily the first cause of action. Regarding the first cause of action, there are primarily two issues before the court: (1) was it unreasonable for United Staffing to claim that the "usual and customary" amount paid to out-of-network providers (in this case, St. Mary's in Grand Junction, Colorado) is the same amount paid to in-network providers; and (2) whether United

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[44]Ficklin Depo. p. 44, at 9-18.

[45]*Gilbertson v. Allied Signal, Inc.,* 328 F.3d 625 (10th Cir. 2003).

Staffing wrongfully denied the Geddes's claim for benefits based on its conclusion that Andrew's stay at Primary Children's in Salt Lake City, Utah was primarily for rehabilitation. Before addressing the St. Mary's and Primary Children's claims, the court will briefly address United Staffing's new argument regarding pre-certification.

The Belated-Raised Pre-Certification Issue

During oral argument on these motions for summary judgment, United Staffing contended that because no pre-certification was given for in-patient hospital care after July 11, 2002 (the date Andrew was transferred to Primary Children's), its denial of benefits was entirely justified. The court believed this was the first time United Staffing had raised this issue. United Staffing, however, insisted that it had raised the pre-certification issue in its briefs. Having again reviewed United Staffing's briefs in search of this pre-certification argument, the court is convinced that at no time before the hearing did United Staffing present this contention. Moreover, at the oral argument, the court ordered supplemental briefing on the issue of which charges could be easily identified as "rehabilitative." Instead of discussing only that narrow question, United Staffing spent over half of its brief on its newly-raised pre-certification argument. Of course, the orderly presentation of arguments on summary judgment does not allow such belated presentation of an issue. Therefore, because United Staffing waited until its oral argument and post-argument briefs to raise this issue, the court will not consider it. The matter should have been raised in United Staffing's response to the Geddes' motion for summary judgment.[46]

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[46]*See Charleswell v. Chase Manhattan Bank, N.A.*, 223 F.R.D. 371, 377 (D. VI 2004); *Coke v. Long Island Care at Home, Ltd.*, 267 F. Supp. 2d 332, 336 (E.D.N.Y. 2003); *United States v. Medeiros*, 710 F. Supp. 106, 110 (M.D. Pa. 1989);.

The Out-of-Network St. Mary's Claims

United Staffing failed to calculate the allowable amounts for services rendered at St. Mary's in accordance with the Plan's terms. The Plan provides that services for out-of-network providers are covered, but only up to an "allowed amount." The Plan defines the "allowed amount" as "the usual and customary amount determined by the Plan." United Staffing's interpretation of what is "usual and customary" is unreasonable considering that a plan participant would have no reason to anticipate that such language would refer to amounts previously negotiated for and agreed upon with in-network providers.

"Under the de novo standard of review, the Court considers the relevant documents in the record to determine the proper interpretation of the disputed provision in [the Plan].[47] The Supreme Court has held that any ambiguities in an ERISA plan must be construed against the employer, as the drafter of the disputed document, in accordance with trust and contract principles of construction.[48] Furthermore, when reviewing the denial of benefits *de novo*, "the burden is on the Defendants to prove that Plaintiffs' interpretation of the [Plan] is unreasonable."[49] And lastly, while the court is limited to the administrative record when conducting a review under the arbitrary and capricious standard, the court may, when reviewing a plan administrator's decision under a *de novo*

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[47]*Rubio v. Chock Full O'Nuts Corp.*, 254 F. Supp.2d 413, 427 (S.D.N.Y. 2003) (citing *Perreca v. Gluck*, 295 F.3d 215, 223 (2nd Cir. 2002)).

[48]*See Firestone*, 489 U.S. at 110-12.

[49]*Rubio*, 254 F. Supp.2d at 428.

standard, "supplement the administrative record 'when circumstances clearly establish that additional evidence is necessary to conduct an adequate *de novo* review of the benefit decision.'"[50]

Immediately after sustaining his injury, Andrew was transferred to St. Mary's in Colorado, an out-of-network provider. St. Mary's billed the Geddes for $86,460.70. In turn, United Staffing paid less than half of the amount billed ($37,363.66), leaving the Geddes responsible to pay the remaining amount. The court must interpret the Plan "as it would any other contract claim by looking to the terms of the plan."[51] The applicable Plan language defining "allowable expenses" seems straightforward:

> For services provided by a non-participating provider, the usual and customary amount as determined by the Plan.

The problem lies not in the definition, but in the Plan's failure to provide any guidance as to how it will determine what is "usual and customary." Typical practice in the industry is to provide an explanation or schedule of benefits defining what is usual and customary.[52] Without such guidance, a plan participant has no warning of liability until a denial of benefits arrives in the mail.

Cases interpreting similar language have generally involved either a schedule of benefits or some other explanation in the Plan specifically defining these terms.[53] For example, in the Tenth Circuit's case of *Hickman v. Gem Insurance Company*, the plan defined "usual and customary" as

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[50]*Hall v. Unum Life Ins. Co. of America*, 300 F.3d 1197, 1202 (10th Cir. 2002) (quoting *Quesinberry v. Life Ins. Co. of North America*, 987 F.2d 1017 (4th Cir. 1993)).

[51]*Hickman*, 299 F.3d at 1212.

[52]*See id.*; *Schwartz v. Oxford Health Plans, Inc.*, 175 F. Supp.2d 581, 589 (S.D.N.Y. 2001). *See also* DARCY HITESMAN ET AL., ERISA COMPLIANCE FOR HEALTH AND WELFARE PLANS 268 (2004).

[53]*See Hickman v. GEM Ins. Co., Inc.*, 299 F.3d 1208, 1212 (10th Cir. 2002); *HCA Health Services of Georgia, Inc.*, 240 F.3d 982, 996 (11th Cir. 2001); *Schwartz*, 175 F. Supp.2d at 589.

"[t]he currently prevailing charge made for a medical service or item by a majority of health care providers of the same discipline [or] type within the same geographical area as determined by the Company."[54] And in *Schwartz v. Oxford Health Plans, Inc.*, decided by the U.S. District Court for the Southern District of New York, the policy manual defined "usual, customary and reasonable" ("UCR") as follows:

> A UCR schedule is a compilation of maximum allowable charges for various medical services. They vary according to the type of provider and geographic location. Fee schedules are calculated using data compiled by the Health Insurance Association of America (HIAA) and other recognized sources. What We Cover/reimburse is based on the UCR. . . ."[55]

Without language defining what "usual and customary" means, the ultimate question then becomes whether United Staffing's interpretation is reasonable. United Staffing concedes that the Plan lacked a definition, but argues, essentially, that it has discretion to interpret the clause "usual and customary." United Staffing interprets the "usual and customary" clause to mean payment at discounted in-network rates rather than what most insurance companies interpret it to mean (amounts determined by comparing similar services in an applicable geographic area).

The court finds United Staffing's interpretation is unreasonable. The Eleventh Circuit has helpfully analyzed this issue.[56] Discussing what is "usual and customary," the Circuit explained that "[a] prudent person . . . . would not consider a discounted fee [to be usual and customary] because it only arose out of a *specified contractual relationship*. The usual and customary fee is the

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[54]299 F.3d at 1210 (emphasis removed).

[55]*Schwartz*, 175 F. Supp.2d at 583.

[56]*HCA Health Services*, 240 F.3d at 996-98.

reasonable fee and, as such, is the fee recognized by a prudent person."[57] The Circuit was not interpreting the phrase "usual and customary" as it existed in the plan, but instead was using "usual and customary" to arrive at a sensible definition of an ambiguous term within the plan. Nonetheless, the Circuit's analysis is persuasive as applied to this case. The Eleventh Circuit went so far as to determine that payment of a discounted rate to providers who had not negotiated such rate was arbitrary and capricious.[58] The court expressed concern that paying out-of-network providers at the same rate as in-network providers ultimately would deleteriously affect plan participants.[59] Explaining this point, the court reasoned that the interpretation of "usual and customary" as in-network would in effect turn a discounted fee negotiated between a specific provider and a specific insurance company into the usual and customary fee for the entire medical industry.[60] This court agrees. In the absence of some explanation, guidance, or definition of "usual and customary" as applied to the Plan, United Staffing's approach of paying out-of-network providers the same discounted rate it has contractually arranged to pay in-network providers is an unreasonable interpretation of the Plan's plain language.

The question then arises as to what is the reasonable interpretation of usual and customary. The Geddes argue that the billed amount was the usual and customary amount, and United Staffing has placed all its eggs in the in-network basket. Accordingly, the court must agree with the Geddes'

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[57] *Id*. at 997.

[58] *Id*. at 1009.

[59] *Id*. at 1008.

[60] *Id*.

position. United Staffing is directed to cover the St. Mary's invoices as billed, less (of course) what it has previously paid.

The Primary Children's Hospital "Rehabilitation" Claims

The next issue is whether United Staffing properly denied claims from the Geddes for charges incurred at Primary Children's because they were primarily rehabilitative. As explained earlier, the court reviews United Staffing's decision to deny benefits under the *de novo* standard of review. Consequently, the court looks to the plain language of the Plan.

The Plan indicated that "In-patient Hospital Services" were covered at a rate of 80% with no annual limit. On the other hand, the Plan contains a $2,500 annual limit for in-patient hospital care for certain rehabilitative services, specifically "[h]ospital confinement primarily for physiotherapy, hydrotherapy, intravenous drug administration, convalescent care, or rest care are not covered." The dispute in this case, then, boils down to whether Andrew's care was primarily for these specified rehabilitative services.

United Staffing points to the billing codes on the invoices from Primary Children's as the basis for its denial based on its conclusion that Andrew's care was rehabilitative. Some of the billing codes for Andrew's care are within the "97000 range," which apparently indicates the care is rehabilitative. However, this summary assumption ignores the terms of the Plan. It is clear from the undisputed evidence that United Staffing did not review the medical records and instead simply relied upon billing codes on invoices to determine whether to pay benefits. This simplistic review may be an appropriate "first cut" for plans in determining whether to pay a claim initially; but in a complicated and difficult case such as this, a cursory review cannot reasonably support a final determination.

Calling Andrew's treatment rehabilitative care would be inconsistent with the conclusion of Andrew's treating physician at Primary Children's that his injuries required a two-month in-patient stay. In a recently-submitted declaration, Dr. Terese Such-Neibar confirmed that none of Andrew's care at Primary Children's could have been provided in an alternative setting. United Staffing has argued that the court is not to consider this evidence because it was not presented to United Staffing (or Everest) at the time the denial of coverage was made, but was prepared after the decision to deny benefits had already been made. United Staffing's position is misplaced in light of the court's conclusion that *de novo* review is appropriate. The Tenth Circuit recently considered what is the proper evidentiary scope of review in *de novo* ERISA cases. In *Hall*, the Circuit instructed that district courts could supplement the administrative record in exceptional circumstances in *de novo* ERISA cases because "supplementation would preserve the procedural rights employees were entitled to prior to the enactment of ERISA and 'help protect employees' substantive rights in those limited circumstances where extra-record evidence is relevant and necessary.'"[61] The special facts of this case qualify as the type of limited circumstance referred to in *Hall*. In particular, the medical condition and subsequent treatment are so complex that additional evidence is required for the court to effectively undertake its own *de novo* review of whether United Staffing's denial of benefits was justified under the Plan. Moreover, even if the doctor's affidavit was disregarded, substantial evidence nonetheless demonstrates that the primary purpose of Andrew's hospital stay was non-rehabilitative.

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[61] *Graham v. Lincare, Inc.*, 2004 WL 3104821 (D.N.M. Feb. 23, 2004) (quoting *Hall*, 300 F.3d at 1202).

The court finds significant that Everest acknowledges it "extensively" reviewed Andrew's medical records and admitted that his care at Primary Children's was "medically necessary."[62] A great deal of Andrew's medical care involved needs that had nothing to do with physiological, hydrotherapy, intravenous medication, or rest care. For three weeks Andrew remained in a halo — a device pinned directly to his skull — to insure stabilization of his spinal cord. Due to frequent vomiting, he intermittently required intravenous feeding. Additionally, Andrew was treated for side effects from the paralysis. The staff monitored Andrew to insure his paralysis did not cause a common, and potentially fatal condition called dysreflexia. He had constant bowel and bladder monitoring. He had on-going respiratory services as well as radiological assessments. And, he had continuing treatment for abnormal involuntary movements. The numerous notes from the nursing staff also confirm Andrew's need for constant monitoring.

Dr. Such-Neibar's assessment of Andrew on his first day at Primary Children's indicated Andrew had a C-R Asia Class C Spinal injury, which had been complicated by a urinary tract infection. Dr. Such-Neibar immediately made numerous recommendations for his care including: bowel program, bladder program, treatment for infectious disease, treatment for spasticity, pain control, *and rehabilitation*. Even Everest's own computer screen capture notes that the Primary Children's invoices "Diagnosis and Service Codes" regarding Andrew list: Abnormal involuntary movements, other musculoskeletal-symptoms referable to limbs, late effect of spinal cord injury, and other rehabilitation procedure.

A determination that Andrew's *entire* stay at Primary Children's was rehabilitative, however, would be incorrect. The medical records demonstrate that Andrew's in-patient stay at Primary

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[62] Buhler Declaration, Exhibit L.

Children's was medically necessary and that the bulk of the expenses were not rehabilitative. But a few of the expenses were rehabilitative. After hearing oral argument in this case, the court ordered both parties to provide supplemental briefing relating to non-rehabilitative expenses. Based on the figures submitted by both parties, of the $99,462.05 in total charges from Primary Children's, $17,804.50 (the amount identified by United Staffing) of that amount is for physical therapy. The court presumes that United Staffing has already paid $2,500 of the $17,804.50 (the amount allowed for rehabilitative services under the Plan). If the court's presumption is wrong, the court orders United Staffing to pay up to that amount. Therefore, with regard to the Primary Children's claim, the Geddes are entitled to a judgment of $81,657.55 (plus any amount owed, up to the policy's $2,500 limit, for rehabilitative services).

Other ERISA Claims

In the complaint, the Geddes also claimed that United Staffing breached its fiduciary duties and failed to provide documents in violation of ERISA. Though the Geddes seek summary judgment on their "ERISA claims," they have raised no arguments in support of these two ancillary claims. Without any opposition to United Staffing's arguments in favor of dismissing these claims, the court GRANTS summary judgment for United Staffing on the Geddes second and third causes of action.

Attorney's fees

Under ERISA, a district court "in its discretion may allow a reasonable attorney's fee and costs of action to either party."[63] The Tenth Circuit has set forth a non-exhaustive list of factors that the district court should consider when exercising its discretion to award fees: "(1) the degree of the offending party's culpability or bad faith; (2) the degree of the ability of the offending party to satisfy

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[63] 29 U.S.C. § 1132(g)(1).

an award of attorney fees; (3) whether or not an award of attorney fees against the offending party would deter other persons acting under similar circumstances; (4) the amount of benefit conferred on members of the plan as a whole; and (5) the relative merits of the parties' positions." While there is not much evidence suggesting that United Staffing acted in bad faith, the remaining factors announced by the Tenth Circuit are supported by substantial evidence. First, there has been no evidence presented by United Staffing that suggests that it is not in the position to satisfy an award of attorney's fees. Second, the court believes that by ordering United Staffing to pay the fees, it will in the future be deterred from failing to review its claim administrators' decisions or at least will properly delegate fiduciary responsibilities to those administrators. Third, such a deterrent effect will undoubtedly result in a benefit to the plan members as a whole; each claim will now be reviewed by a fiduciary, and plan participants will be on notice of how out-of-network charges will be paid. And lastly, the relative merits of the parties' position were determined in favor of the Geddes. Therefore, having considered the relevant factors, the court awards reasonable attorney's fees to the Geddes.

Conclusion

The court GRANTS summary judgment for the Geddes on their first cause of action[19-1]. As for the Geddes's second and third causes of action, the court GRANTS summary judgment in favor of United Staffing[16-1].

It is therefore ORDERED that the Geddes have proven their first cause of action under ERISA and is therefore entitled to a judgment for payment of benefits denied except for those specifically referred to as "rehabilitative." United Staffing shall pay for Andrew's stay at Primary Children's according to the in-patient benefit rate listed in the Plan. The Geddes are also entitled to an award of attorney's fees under 29 U.S.C. § 1132(g). To enable the court to enter a final judgment, the plaintiff shall have 21 days from the date of this order to submit a form of judgment accompanied by computations of the amounts to be included, with the necessary affidavits and supporting information for determining an award of attorney's fees. United Staffing shall then have 21 days after receipt of the Geddes's submission to file objections.

Dated this 23rd day of March, 2005.

SO ORDERED.

/S/

Judge Paul G. Cassell
United States District Court

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United States District Court
for the
District of Utah
March 23, 2005

* * CERTIFICATE OF SERVICE OF CLERK * *

Re: 2:03-cv-00440

True and correct copies of the attached were either mailed, faxed or e-mailed by the clerk to the following:

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